Substance Abuse and Mental Health Services Administration

SAMHSA NEWS

SAMHSA's Award-Winning Newsletter

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American Indian Practices Converge in a "System of Care" for Children

The statistics are alarming: Almost 20 percent of American Indian and Alaska Native teenagers age 12 to 17 use illicit drugs—the highest rate of any group in the country according to SAMHSA's 1999 Household Survey on Drug Abuse. Alcohol-related deaths for American Indians and Alaska Natives age 15 to 24 are 17 times higher than the national average. And according to the Indian Health Service's 1997 *Trends in Indian Health*, suicide rates for American Indians and Alaska Natives age 5 to 24 are almost triple that of American young people overall.

Yet mental health and substance abuse services for American Indian and Alaska Native children and adolescents have been sorely lacking. Extreme poverty, geographic isolation, incompatibility with non-Indian approaches, and other factors have limited access to services, according to a new monograph, *Cultural Strengths and Challenges in Implementing a System of Care Model in American Indian Communities*, published by SAMHSA's Center for Mental Health Services (CMHS). All too often, Indian youth with emotional problems are placed in long-term treatment hundreds or even thousands of miles from their homes.

Now, an ongoing project is trying to determine the best way to get mental health and substance abuse services to American Indian, Alaska Native, and other children and adolescents in need. Launched by CMHS in 1993, the Comprehensive Community Mental Health Services for Children and Their Families program encourages the development of community-based services for children with serious emotional problems and their parents. Five of the grantees that are American Indian organizations are profiled in the new monograph (see *SAMHSA News* p. 10).

Known as the Child Mental Health Initiative for short, the grant program is an attempt to put a philosophy known as "system of care" into practice.

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Photo courtesy of the Administration on Aging

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SAMHSA To Host 3rd National Women's Conference

SAMHSA's Third National Conference on Women, *A Generational Journey: Women Carrying the Vision, Common Issues, United Voices*, will be held June 18 to June 21 in Orlando, FL. The conference is being held to increase commitment to women's issues within the health and social service arenas, to apply knowledge developed by the field to improve service delivery, and to stimulate consultation, share best practices, and network across disciplines.

Preconference symposia, plenary sessions, workshops, and poster sessions will address topics including children and youth, living with HIV/AIDS, work and the workplace, access to and utilization of health care, violence across generations, research, diversity and inclusiveness, girls and women in institutional settings, public policy and legal issues, sustainability, community issues, the wisdom and needs of seniors, and consumers/survivors/recovering persons.

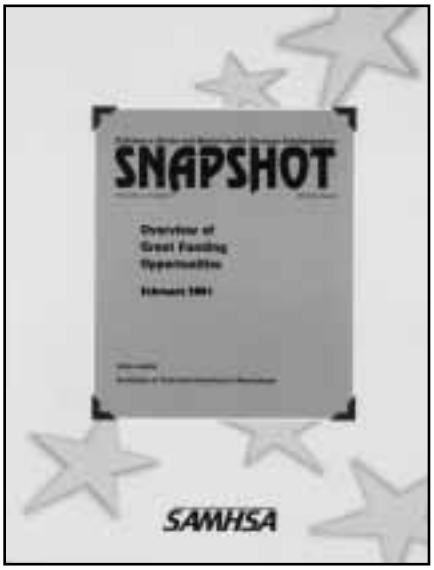
The early-bird registration fee (received by May 1) is $175; the standard registration fee (after May 1) is $200. The submission deadline is March 2 for those interested in presenting at the conference or receiving financial assistance.

To register or for further information, contact: Third National Conference on Women, c/o Courtesy Associates, 2000 L Street, NW, Suite 710, Washington, DC 20036. Phone: (202) 973-8657.

Fax: (202) 331-0111. E-mail should be sent to **women@courtesyassoc.com**. Or contact Duiona Baker, SAMHSA Women, Children, and Families Team, (301) 443-5184. For the most current information, visit the Third National Conference on Women at **www.samhsa.gov,** and click on Latest Announcements.

Snapshot Offers Array of Grant Opportunities

Seeking funding for your program? A valuable resource is available from SAMHSA. The second edition of the publication, *Snapshot*, will be available in early March. It provides potential grant applicants with a preview of the Agency's funding opportunities in substance abuse prevention, addiction treatment, and mental health services for Fiscal Year 2001.



The volume provides a brief overview of how SAMHSA's grant process works and offers suggestions about how to get started, identifies the elements of an application package, and suggests tips about "what works" in developing and presenting an application. Details are provided for each of SAMHSA's "Guidance for Applicants," including eligibility criteria, project descriptions, funding priorities, expected receipt dates, projected award dates, estimated number of awards, estimated amount of each award, and program contacts.

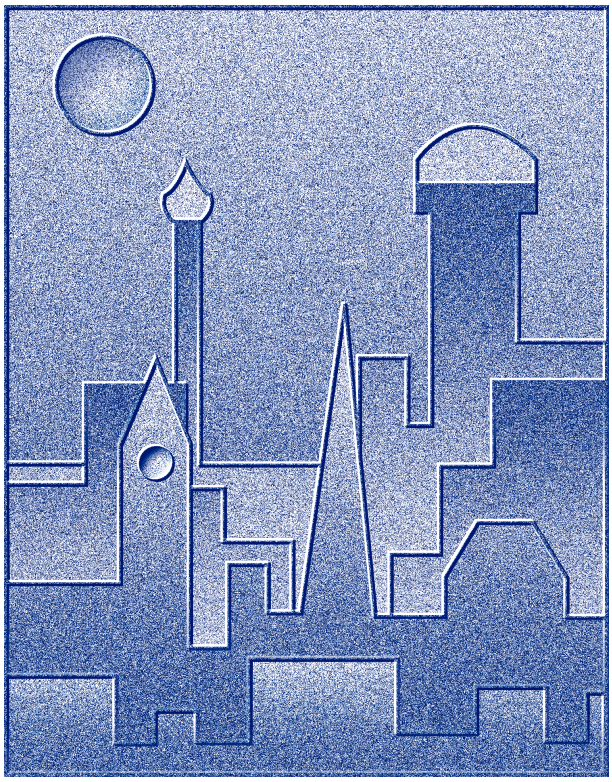
The publication also provides details of planned technical assistance workshops. Potential applicants can take advantage of opportunities provided in these workshops to learn how to prepare grant applications.

To receive a free copy of *Snapshot*, send an e-mail request including your mailing address—with your city, state, and Zip code—to **snapshot@samhsa.gov.** Alternatively, contact SAMHSA's Division of Extramural Activities, Policy, and Review by phone (301) 443-4266 or by fax (301) 443-1587. For Web access: Type **www.samhsa.gov,** then click on Grant Opportunities.

Enhancing Collaboration Between Treatment and Faith Communities

"The faith community historically has played a critical role in delivering services and providing environmental and emotional support to those seeking to recover from drug abuse," said H. Westley Clark, M.D., J.D., M.P.H., Director of SAMHSA's Center for Substance Abuse Treatment (CSAT). "The faith community is a natural part of our constituency. The faith community can offer us their observed experience and recommendations, just as any other provider in the community. They can also offer us information about the epidemiological issues they see happening in clinical practice.

"CSAT can also help the faith community," said Dr. Clark. "CSAT, for example, can provide training on specific aspects of substance abuse treatment, and information about new medications and various physiological and psychological consequences of substance abuse and addiction."



Furthermore, Dr. Clark added, "We know the faith community often provides housing and shelter and comfort as well as a spiritual, philosophical, and theological foundation for an addict's recovery. . . . We can work with the faith community in its relationships with other service systems and Federal components such as the Department of Housing and Urban Development and the Department of Justice."

Just such a mutual effort took place recently, organized by CSAT, One Church-One Addict, The Congress of National Black Churches, Inc. (CNBC), and the Johnson Institute Foundation. Together, the organizations cosponsored a 2-day conference titled "Strengthening Faith-Based Drug Education, Prevention, and Treatment Through Collaboration."

The conference, held at Gallaudet University's Kellogg Center, in Washington, DC, outlined ways for individuals working through their churches to make dramatic progress in reducing local drug abuse. The conference, which coincided with CSAT's *Recovery Month* in September, offered tips on how and where to seek financing for alcohol and drug addiction programs, the names of other organizations that share the same goals, and sources within local, state, and Federal agencies that could help surmount the hurdles that impede faith-based groups trying to start drug addiction rehabilitation centers.

The conference also gave members of CNBC—representing approximately 20 million persons—a chance to ask questions both theoretical (e.g., Will privatization of drug facilities work in the District of Columbia as it has in other places?) and practical (e.g., What can you do for an addict after 30 days of treatment when drug abuse cannot be treated in so short a time?).

The conference was one of a series of five meetings held in Chicago, Baltimore, the District of Columbia, Minneapolis, and Austin to create a stronger network of faith organizations operating alcohol and drug prevention and treatment programs that are certified or have appropriate recognized skill competencies to address the complexities associated with substance abuse in their communities.

Clifton Mitchell, Special Expert to the Director, CSAT, Faith Initiative, stressed the importance of regular interaction. Mr. Mitchell said key ministers should get together for at least one annual citywide meeting to keep up-to-date with the latest research and new funding sources. To qualify for funding, however, Mr. Mitchell said doctors, care practitioners, church counselors, and key staff members need to be fully trained and certified. By taking this approach, he explained, these individuals will be able to promote good health, bill for their services, and extend their work even further.

Churches in the Black community, speakers noted, have a unique role to play in the campaign against drug abuse throughout the country. Because addicts seeking help tend to gravitate to nearby

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grassroots churches, local ministers have the earliest opportunity to give addicts not only a handout but a hand up. Government speakers stressed repeatedly, however, that churches lacking experience working with drug addicts and alcoholics need to network with an area treatment program that has been in practice for at least 2 years. This type of partnership will also help clergy and volunteers learn how to obtain funding from various sources, such as government agencies and private foundations.

Speaker Harriet McCombs, Ph.D., a senior mental health advisor with the Health Resources and Services Administration, acknowledged, "The drug addiction epidemic cannot by solved by one agency alone. So we are looking to develop strong partnerships to have the greatest impact. We must look around to maximize our abilities."

Part of this effort to maximize resources is reflected in recent language incorporated into SAMHSA's reauthorization legislation. The passage of Public Law 106-310 provides additional impetus to SAMHSA to work with the faith community. The law permits religious organizations that provide substance abuse treatment services to receive Federal funding while maintaining their religious character and their ability to hire individuals of the same faith.

Dr. Clark said, "CSAT can help provide education for clergy and religious leaders. We can encourage seminaries and faith-based training programs to include some of the technical and science-based information about substance abuse in their training of their rabbis, pastors, imams, priests, and monks so that when they enter the field to provide assistance to a wide range of individuals they have some knowledge base to work with."

Although participants acknowledged the strategic importance of local Black churches in the fight against the citywide epidemic of drugs, the ministers also warned of the necessity for all members of the clergy to "keep their own houses in order."

The Reverend Dr. Lewis M. Anthony, senior pastor of the Metropolitan Wesley A.M.E. Church, pointedly asked, "Are your ushers specialists in hospitality or are they security guards watching out for who looks right, smells right, or acts right?" Even though an addict may be desperately searching for sanctuary or solace, Rev. Anthony said, he or she can immediately sense disapproval and turn away from the haven that offers the best chance for recovery.

. . . Churches . . . need to network with a treatment program in practice for at least 2 years.

Also, church members are not necessarily aware of local conditions. In many congregations, even though parishioners continue to attend their favorite churches, few of them still live in the neighborhood. Speakers estimated that as many as 85 percent of those who attend city churches are strictly Sunday visitors. Consequently, these churchgoers may no longer have a vested interest in the neighborhood or may be unaware of the drug abuse problems that chip away at the foundations of the community.

Those who are already working in the area of drug abuse should keep abreast of current discoveries and new methods of treatment, participants said. And those who are preparing for pastoral work should not wait until they receive their first assignment. Conference participants agreed that seminarians should already be in training so that they will be able to assist recovering alcoholics and drug addicts as soon as they arrive in their parishes.

"Such steps further enhance the faith community's ability to combat drug addiction early on," said Dr. Clark. "The faith community needs to be aware that a person with pastoral training alone may not understand a seizure disorder secondary to alcohol withdrawal, or may not understand chest pain secondary to cocaine or methamphetamine use. So, SAMHSA can offer specific knowledge through our Addiction Technology Training Centers, through our Treatment Improvement Protocols, and through technical assistance in working with specific populations or specific drugs."

Conference speakers repeatedly underscored the need for continuing education for those who work with addicts. Julia Walker Maxwell, L.I.C.S.W., C.A.S., branch director of the Mental Health Addiction Service, emphasized that extensive training is necessary.

Ms. Maxwell said that people helping addicts to recover need to realize that addiction is often not the sole dilemma to be resolved. Many addicts have multiple health problems and poor social skills, which make it difficult for them to find employment and housing. The counselors must be able to spot these problems, and if they cannot treat these as well, seek out specialists who can.

A conference report will be released in 2001.

— By James H. Mooney

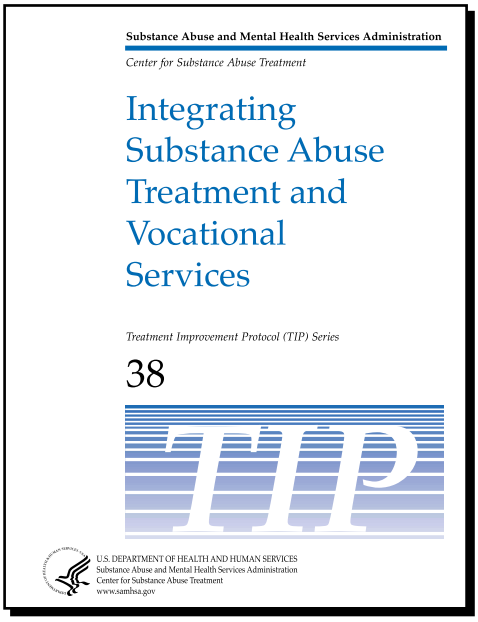
Vocational Services Essential for Substance Abuse Treatment Success

A newly released Federal treatment guidelines report reveals that effective vocational training and job placement assistance are critical to the recovery and rehabilitation of individuals with a substance abuse problem.

In its new Treatment Improvement Protocol (TIP)—*Integrating Substance Abuse Treatment and Vocational Services*—SAMHSA's Center for Substance Abuse Treatment (CSAT) addresses the association between recovery from addiction and the need for employment services. "Years of research show that gainful employment is one of the best predictors of successful substance abuse treatment," said SAMHSA Acting Administrator Joseph H. Autry III, M.D. "However, substance abuse treatment that is cost-effective and produces demonstrably successful results cannot be achieved unless *all* of an individual's service needs are met. This will occur only through integration of treatment with other key services, including vocational counseling."

TIPs are "best practices" guidelines developed by a consensus panel of experts to provide guidance for the treatment of substance abuse. The vocational services TIP, the 38th in a CSAT-published series, includes data on the prevalence of substance abuse and its relationship to employment. According to the report, unemployment rates among people with substance abuse disorders are much greater than those of the general population, notwithstanding the comparable educational levels of the two groups.

A 1997 survey showed that some 13.8 percent of jobless adults used illicit drugs before or at admission to treatment, compared to only 6.5 percent of others employed full time. Employment also reduces the severity and frequency of relapses, according to the publication.



CSAT Director H. Westley Clark, M.D., J.D., M.P.H., notes that TIP 38 is applicable across many professional disciplines. "The publication will be useful to vocational rehabilitation staff, social service workers, those who work within the criminal justice system, and all others involved in arranging and providing vocational and substance abuse treatment services. This TIP is a tool to help providers better understand how work enables people to recover from substance abuse and to improve their ability to help clients obtain gainful employment," he said.

The report found that a compelling need exists for interventions that improve employment rates among drug users in treatment and recovery. In particular, securing employment should be included as a discrete goal within an individual's substance abuse treatment plan. Moreover, treatment programs should have on staff at least one vocational rehabilitation counselor, and the job-related needs of individual clients should be routinely screened and assessed, the TIP recommends.

Other TIP 38 recommendations include:

Individual client attitudes toward work and work goals should be considered clinical issues with an impact on recovery.

Federal disability, welfare, and child protection laws as they affect substance abusers have changed. Accordingly, treatment professionals must simultaneously provide appropriate support to clients and stress the urgency of attaining or maintaining sobriety and finding employment.

For work to be sustained and enduring lifestyle changes effected, vocational services provided to those in recovery must focus on barriers to employment, the skills required to acquire and maintain a job, and on-the-job satisfaction.

Providers must assume that it is not feasible to provide everything that clients need "under one roof." Instead, providers should collaborate with other service agencies, based on individual client needs.

For a copy of TIP 38, contact SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) at P.O. Box 2345, Rockville, MD 20847-2345. Telephone: 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD). Web access: Type **www.samhsa.gov**, click on CSAT, click on SAMHSA publications, then click on TIPs.

National Treatment Plan Initiative Offers Blueprint for Change

A new consensus report with recommendations for improving the way in which alcohol and drug treatment services are delivered and paid for was released recently by SAMHSA's Center for Substance Abuse Treatment (CSAT). The report is the first product of the National Treatment Plan Initiative. Launched in fall 1998, the Initiative is designed to provide an opportunity for the field to reach a working consensus on how best to improve substance abuse treatment, and then to pursue action to effect needed change.

Estimates suggest that there are 13 to 16 million people in need of treatment for alcohol or drug abuse in any given year, but only 3 million receive treatment. The recommendations in the report are intended to help close the gap and improve the quality of substance abuse treatment services.

The report, *Changing the Conversation: Improving Substance Abuse Treatment: The National Treatment Plan Initiative,* calls for development of commonly accepted standards for what constitutes effective substance abuse treatment in the United States. It also recommends that insurers adopt standard insurance benefits that would allow for a continuum of treatment services appropriate to a patient's needs, similar to other medical conditions.

The report was drafted by five expert panels that included researchers, people recovering from drug and alcohol addiction, treatment providers, and community representatives. Input was also received from hundreds of participants in five regional hearings and written comments submitted to CSAT. (See *SAMHSA News,* Summer 2000.)

The recommendations contained in the report cross all sectors, public and private, of the Nation's substance abuse treatment system.

According to CSAT Director H. Westley Clark, M.D., J.D., M.P.H., "CSAT sees this as the beginning of the end of a fragmented system of substance abuse treatment. We will work with the treatment field to apply the guidelines contained in the plan to the organization, delivery, and financing of high-quality treatment services for children, adolescents, and adults with substance abuse problems."

The plan is guided by five major principles. First, for resources to be used most effectively, there must be an "Investment for Results." The plan recommends development of a standard insurance benefit package. It also calls for development of reimbursement mechanisms aligned with treatment goals that incorporate both performance measures and outcome standards, and that ensure rates sufficient to cover costs with a surplus for reinvestment.

The plan is also based on the principle that there should be "No Wrong Door for Treatment." When a substance-abusing person presents for treatment for any condition at any point in the health care system and gives indications of substance abuse, he or she should be guided toward treatment. In addition, other vital systems such as social services, justice, and education will be asked to cooperate in efforts to bring substance abusers into treatment. To be effective, this plan will require that physicians and other primary care health care workers, social workers, teachers, and school administrators become more knowledgeable about substance abuse and the importance of timely intervention.

The plan urges a "Commitment to Quality" at all levels of treatment. The national treatment workforce should be made up of men and women of diverse ethnic groups and cultural backgrounds who can be responsive to their client populations. Treatment professionals should be well trained and appropriately credentialed and certified as required, and fairly compensated for their professional expertise.

The report notes that there is widespread agreement in the medical community that substance abuse dependence is a chronic, relapsing disease that can be treated successfully using recognized best practices. Unfortunately, the report adds, this belief is not shared by the majority of the general public, who believe that most treatment is ineffective, in part, because "partial or inappropriate treatment is both costly and ineffective."

The plan recommends that efforts be made to effect a "Change in Attitudes" by convincing the public that recovery is possible, so that stigma and discrimination against people in recovery is reduced. The document emphasizes the inclusion of the recovery community in all discussions.

Finally, the plan notes that for continued improvement in the quality of care "Partnerships Must be Built." Among the most important partnerships is the one between the research community and the treatment community. Such a partnership is vital if the best evidence-based research is to be accessed and employed by service providers. The plan also recommends encouragement of and support for vital partnerships between the treatment field and individuals and organizations committed to improving treatment.

For a copy of *Changing the Conversation*, contact SAMHSA's National Clearinghouse for Drug and Alcohol Information (NCADI), at P.O. Box 2345, Rockville, MD 20847-2345. Telephone: 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TTD). Web access: Type **www.samhsa.gov,** click on CSAT, and then click on National Treatment Plan.

On the Web: Prevention Program Guidance

Many of the most current, effective strategies for substance abuse prevention are now a mouse-click away. SAMHSA's Center for Substance Abuse Prevention (CSAP) has launched the first prototype of its new online Decision Support System (DSS).

The system is a carefully integrated set of Web-based, interactive software programs that actively guide community practitioners and state system managers through a series of well-informed decisions about a broad range of options useful for prevention programs.

The system provides step-by-step procedures for assessing needs, building capacity and identifying resources, selecting and implementing the best and most promising interventions, developing outcome evaluations, and writing reports. Online technical assistance and training is provided each step of the way. State system managers can also access a special software developed for managing Substance Abuse Prevention and Treatment Block Grant funds.

"The Decision Support System is the capstone in CSAP's efforts to build a national prevention system," said CSAP Director Ruth Sanchez-Way, Ph.D. "The new system complements our registry of effective prevention programs, supports our regional Centers for the Application of Prevention Technologies, and helps states and grantees bring prevention science into practice."

In addition to assisting practitioners and state system managers in assessing local needs, gathering resources, and choosing science-based prevention programs, the Web site provides support for the following:

- Training in DSS uses
- Learning scientific prevention methods, training curricula, and best practices online
- Adapting the selected programs to local context and cultures

- Viewing the program's resource requirements, practice manuals, and evaluation measures
- Enhancing state prevention management information systems.

CSAP encourages the public to view the system, try it out, and recommend improvements. To access the system: Type **www.samhsa.gov**, click on CSAP, then click on CSAP's Decision Support System.

Coalition Launched in Response to Supreme Court Decision

More than 40 Federal agencies, national mental health advocacy organizations, consumer groups, and private sector companies met in December for the first time to launch a national coalition to promote community-based care for persons with mental illness.

The meeting was sponsored by SAMHSA's Center for Mental Health Services (CMHS). Formation of this new coalition was announced in connection with the 10th Anniversary of the Americans with Disabilities Act (ADA). The new measures promote home and community-based services for people with disabilities.

Under the ADA, states are required to provide services to persons with disabilities in well-integrated community settings rather than in institutions.

On June 22, 1999, the U.S. Supreme Court issued a landmark decision in the case of *Olmstead vs. L.C.* Under the ADA, states are required to provide services to persons with disabilities to the greatest extent possible in well-integrated community settings rather than in institutions. The Court upheld that the ADA prohibits the unjustified isolation of people with disabilities in institutions, especially when those individuals can benefit from home- and community-based services and choose to access such services, and when state resources are available to support such services. The ruling reinforced the fundamental intent of the ADA—elimination of discrimination based on disability.

"This is a major and needed step to move the Nation toward the goals set forth in the U.S. Supreme Court's Olmstead decision," stated SAMHSA Acting Administrator Joseph Autry III, M.D. "With access to needed medical and mental health services as well as supportive services such as housing and vocational rehabilitation, individuals with mental illnesses can thrive in their community. This broad-based coalition will lead the way."

CMHS is providing $6.3 million to support this timely initiative focused on identifying and developing strategies to eliminate some of the known barriers to comprehensive community-based services. These include:

- Lack of adequate income and job opportunities
- Lack of affordable and appropriate housing
- Gaps in health care services systems
- Community resistance to programs due to discrimination and stigma around mental illness.

During the first year of the project, the national coalition will provide leadership in the development of statewide coalitions to aid in the design and development of comprehensive community mental health service plans. Guidance will also be offered to state coalitions in identifying the latest technical assistance tools, best practices, and best training curricula to help establish links to consumer employment opportunities, housing, transportation, case management, crisis management, and other services. Financial support will be given to all 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands to support an Olmstead coordinator in each jurisdiction.

"This initiative will bolster state and community efforts to realize the needed array of services to support Americans with mental illnesses," said CMHS Director Bernard S. Arons, M.D.

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—Bernard S. Arons, M.D.
CMHS Director

The National Coalition is comprised of representatives of the Departments of Health and Human Services, Housing and Urban Development, Labor, Education, Justice, Transportation, Social Security, the President's Task Force on Employment of Adults with Disabilities, and the Veterans Administration, as well as community leaders from dozens of national organizations.

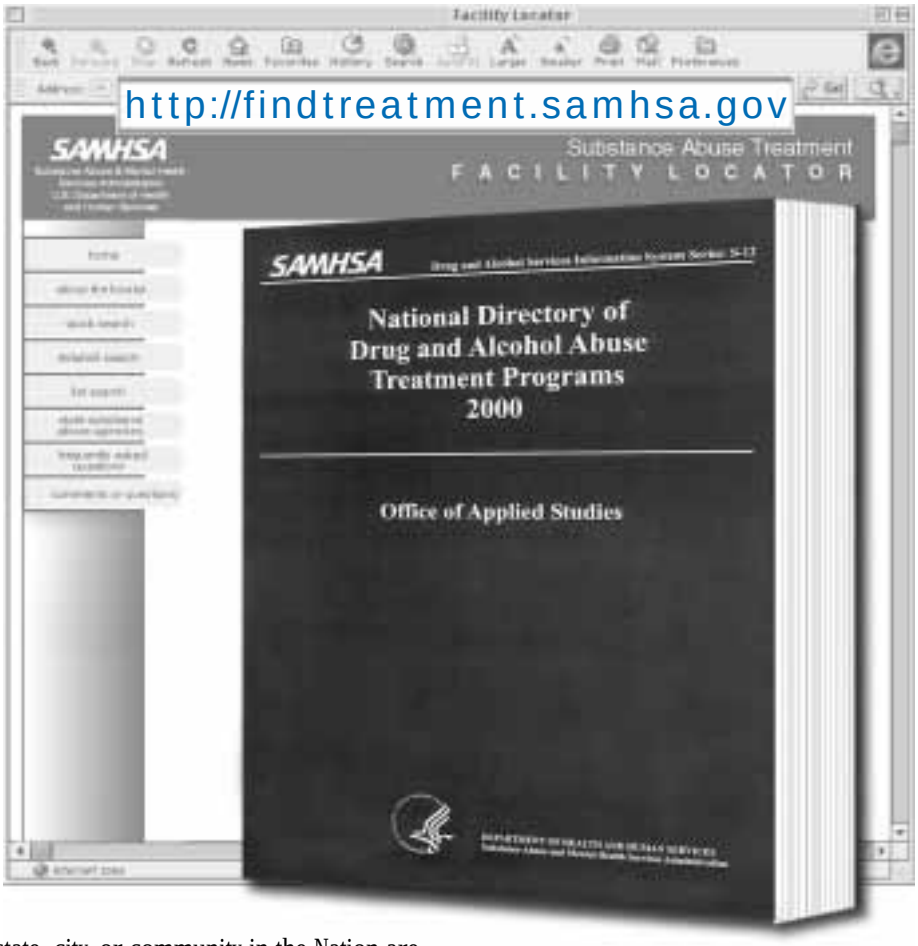
National Drug, Alcohol Abuse Treatment Directory Updated

SAMHSA recently released its updated *National Directory of Drug and Alcohol Abuse Treatment Programs*, a guide containing information on thousands of local treatment programs in each state.

The new directory includes a nationwide inventory of substance abuse and alcoholism treatment programs and facilities at the Federal, state, and local levels as well as private facilities that are licensed, certified, or otherwise approved by substance abuse agencies in each of the 50 states. The directory is organized and presented in a state-by-state format for quick reference by health care providers, social workers, managed care organizations, and the general public.

"This latest and improved edition of the SAMHSA directory of treatment programs provides a listing of the most current information available on substance abuse treatment programs at the community level in each state," said SAMHSA Acting Administrator Joseph Autry III, M.D. "The directory is designed to provide the reader quickly with important information on types of facilities, including programs for adolescents, individuals living with HIV/AIDS, and pregnant women, and the levels of care offered—hospital inpatient, residential, or outpatient—within any geographical area in the country."

The new directory complements SAMHSA's Internet-based *Substance Abuse Treatment Facility Locator* service. The Internet-based service provides road maps to the nearest treatment facilities as well as addresses, phone numbers, and information on services available. Through this service, both public and private substance abuse treatment facilities in any state, city, or community in the Nation are easily and quickly located by following simple instructions at the Treatment Locator Web site.



Uses for the new directory include:

- Accessing quick-reference data for substance abuse and mental health hotlines, crisis centers, and emergency services
- Referring patients for hospitals, health care providers, and social service agencies
- Planning mental health and substance abuse resources at the community, state, and regional levels
- Developing mailing lists and databases for meetings, health fairs, and other events
- Obtaining information on what types of payments are accepted by each facility
- Identifying the types of services provided—detoxification, methadone/LAAM, or halfway houses.

In addition to alcohol and drug abuse treatment service providers, the directory also lists state-level substance abuse treatment authorities.

For a free copy of the *National Directory of Drug and Alcohol Abuse Treatment Programs* (2000), contact SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI), P.O. Box 2345, Rockville, MD 20847-2345, or call (800) 729-6686. Web access: **http://findtreatment.samhsa.gov.**

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The approach calls for a comprehensive array of mental health and other support services for children and adolescents with emotional disturbances and their families. Key characteristics include coordination of services, community involvement, cultural competence, and a child-centered, family-focused orientation.

"The beauty of the system-of-care philosophy is that it fits so naturally with Native American values," said Gary De Carolis, M.Ed., Chief of the Child, Adolescent, and Family Branch at CMHS. "The system-of-care approach is helping to recreate what was always there in Native American communities and what was almost lost over the last century of cultural disintegration."

Overlapping Philosophies

Part of SAMHSA's series, *Systems of Care: Promising Practices in Children's Mental Health*, the *Cultural Strengths and Challenges* monograph illustrates the points of intersection between the system-of-care philosophy and American Indian traditions.

Consider the emphasis on community-based services, for instance. Despite the wide diversity among and even within American Indian and Alaska Native tribes, all groups view community as central. That's especially true when it comes to raising children. "It has always been expected that all would take care of the children," says a service provider quoted in the monograph. "It's a communal way of life."

In keeping with this cultural value, the system-of-care approach recommends that children stay in their own communities and receive the least restrictive services possible. In addition, the approach emphasizes the importance of coordinating services for children across agencies. And community involvement is key. The Kmihqitahasultipon project in Maine, for example, relies on community members to serve as mentors to children and provide respite for family members who need a break.

The importance of kinship is another traditional value at the core of all American Indian cultures. Similarly, the system-of-care philosophy views family members as partners in treatment teams. Family members and children themselves are actively involved in all aspects of planning, carrying out, and evaluating treatment plans. The American Indian projects funded by SAMHSA extend this philosophy even beyond the immediate family, enlisting the aid of grandparents, godparents, and unrelated "aunties" and "uncles" who can provide additional support. Activities that are intergenerational, such as storytelling, bring elders and children together as a way of revitalizing the tradition of multigenerational relationships.

Holism is yet another characteristic common to both approaches. In the traditional American Indian world view, mental health means a balance of mind, body, spirit, and the surrounding

American Indian Project Sites

Cultural Strengths and Challenges in Implementing a System of Care Model in American Indian Communities, a publication in the CMHS series, *Systems of Care: Promising Practices in Children's Mental Health*, highlights five American Indian grantees in the Comprehensive Community Mental Health Services for Children and Their Families program:

- **The K'e Project** serves the Navajo Nation, the country's largest American Indian reservation.
- **Kmihqitahasultipon** serves the Passamaquoddy Tribe in Indian Township on the border between Maine and Canada. The project's name means "We remember."
- **The Sacred Child Project** serves members of the Spirit Lake Nation, Standing Rock Nation, Three Affiliated Tribes, Turtle Mountain Band of Chippewa, and Trenton Indian Service Area in North Dakota and surrounding areas.
- **With Eagle's Wings** serves the Wind River Reservation in Wyoming, home to the Northern Arapaho and Eastern Shoshone Nations.
- **Mno Bmaadzid Endaad** serves the Sault Ste. Marie Tribe and Bay Mills Tribe of Chippewa Indians in Michigan's Upper Peninsula. The project's name means "Be in Good Health at His House."

Recently, three other sites were added to the program. They include:

- **Yuut Calirut Ikaiyuquulluteng** (People Working Together), in Bethel, AK, serves Alaska Native children and families in 58 villages in the Yukon Kuskokwim Delta region.
- **Nagi Kicopi** (Calling the Spirit Back) is a project of the Oglalla Sioux Tribe in South Dakota.
- **The United Health Services of California** serves nine tribal communities in the northwest corner of the state.

environment. Similarly, the system-of-care philosophy emphasizes that children must have access to services that meet their physical, social, and educational needs as well as their emotional needs. In keeping with this shared approach, grantees often include pow-wows, camp-outs, and crafts projects in their roster of activities.

The monograph also identifies 18 specific practices that appear promising (see *SAMHSA News* p. 12). To build on these and other lessons learned from its American Indian grantees, SAMHSA recently funded two other grant programs. Together with the Child Mental Health Initiative, the Community Action Grants for Service Systems Change program, and the Circles of Care: Planning, Designing, and Assessing Mental Health Service System Models for Native American Indian and Alaska Native Children and Their Families program form the basis of a new collaborative effort among the Departments of Health and Human Services, Interior, Justice, and Education. The effort will develop effective strategies to address the mental health and substance abuse needs of American Indian and Alaska Native children and adolescents.

A Closer Look

In the meantime, grantees are already providing services that embody this unique blend of western and Native traditions. "Grantees are drawing on the vestiges of their culture to create new approaches to treating the mental health needs of American Indian children that are steeped in traditional healing practices," said Project Officer Jill S. Erickson, M.S.W., an American Indian and Public Health Advisor in the CMHS Child, Adolescent, and Family Branch.

Ms. Erickson points to the program's Sacred Child grantee as just one example

of how that is happening. Coordinated by the United Tribes Technical College in Bismarck, ND, the project serves an enormous geographic area that is home to the Spirit Lake Nation, Standing Rock Nation, Three Affiliated Tribes, Turtle Mountain Band of Chippewa, and the Trenton Indian Service Area.

According to Sacred Child Director Deborah A. Painte, M.P.A., drawing on American Indian traditions and values is "the only way to heal the historical wounds and intergenerational grief that have created the complex mental health needs that so many American Indian and Alaska Native families and children must struggle with every day."

In tracing the erosion of their culture, American Indians point to a past in which American Indian and Alaska Native children were separated from their parents and sent to Government-funded boarding schools where they were prohibited from speaking their tribal tongue and forced to abandon their native traditions and customs.

The differences between Sacred Child and conventional mental health services are apparent even at first contact between families and the project. Instead of case managers, for instance, the project uses care coordinators who follow cultural tradition. During their initial encounter with families, these care coordinators socialize and build relationships instead of jumping into the intimidating process of taking psychosocial histories.

To give families control, families themselves select more than half of the members of their child and family support

continued on page 12

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teams. The resulting teams thus include extended family, indigenous healers, and elders and other cultural advisors, as well as representatives from the various service providers and Government agencies involved in their children's lives. The project even has parent coordinators, who have children or other relatives with emotional or behavioral problems and can provide additional support to parents.

Together, these support teams develop culturally appropriate treatment plans based on a family's existing strengths. Children and parents choose from among a dozen domains—the priority areas they wish to address. Support teams then help families develop strategies and find the resources they need to fulfill these goals.

One Family's Story

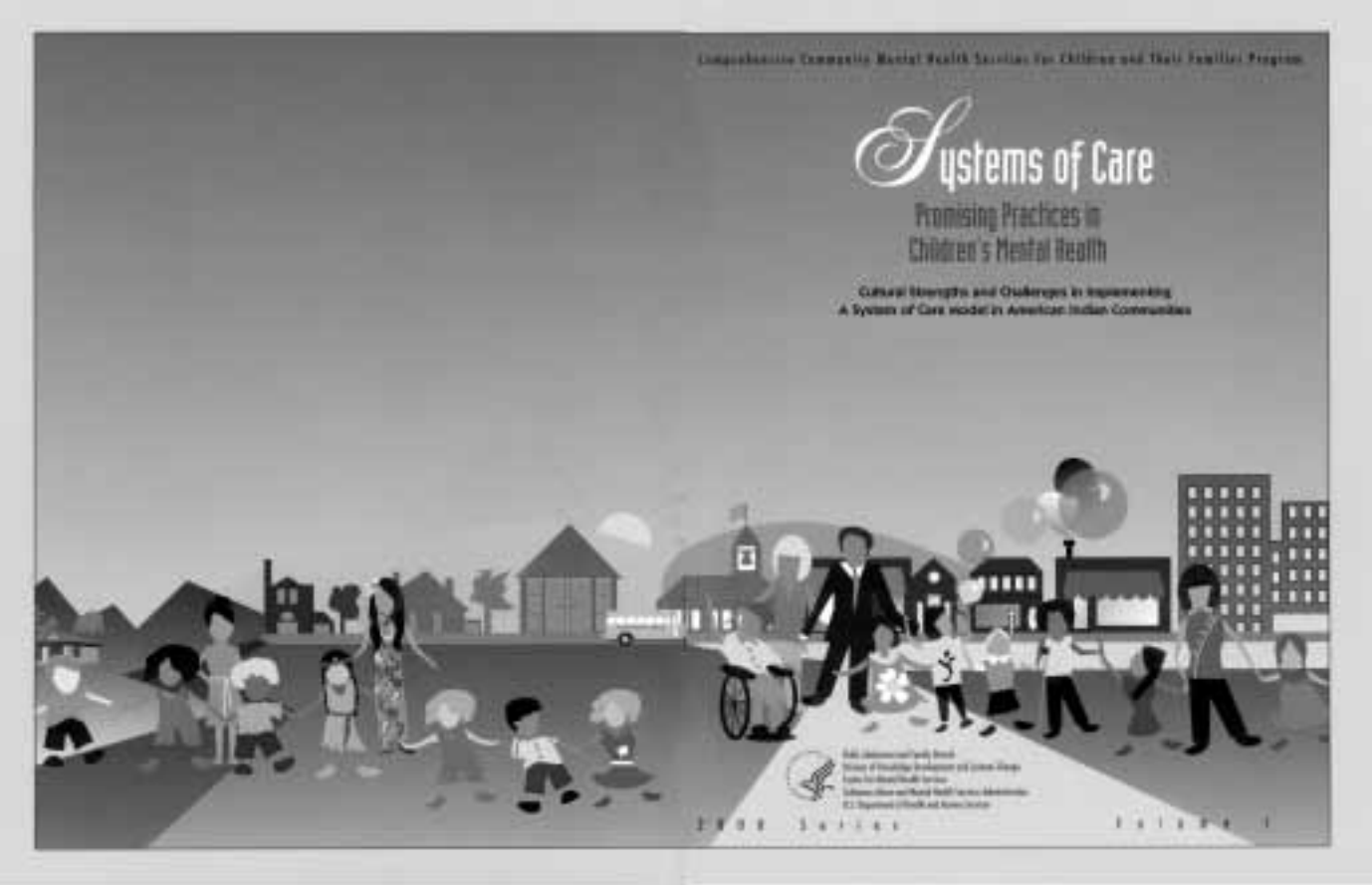
Alice Smith* knows firsthand how well this approach works. When her 12-year-old son dropped out of a Bureau of Indian Affairs boarding school, his file contained a note that recommended counseling but gave no explanation about why it was needed. Ms. Smith tried to find help for her son through the local school, but to no avail. A few months later, Ms. Smith's concern became alarm when she discovered a suicide note in her son's room. Panicked, she called the school's principal and counselors. "They just told me to calm down and go back to work," Ms. Smith recalled. "But I couldn't work. I was terrified my son was going to do something to himself."

Then she remembered a brochure about the Sacred Child Project that one of the school's counselors had sent her. Ms. Smith called the project, and within minutes had set in motion a process that would not only turn her son's life around but also her own. With Sacred Child's help, the boy was hospitalized that day.

Promising Practices

Cultural Strengths and Challenges in Implementing a System of Care Model in American Indian Communities identifies several promising practices developed by SAMHSA's American Indian grantees that blend Native and mainstream concepts:

- Using the extended family
- Drawing on traditional teachings about wellness, balance, and harmony
- Incorporating American Indian approaches, such as storytelling, sweat lodges, and feasts
- Adapting mainstream approaches to reflect American Indian cultural values
- Including activities designed to restore cultural traditions, such as mentoring programs and craft projects
- Promoting a positive view of American Indian identity
- Using methods that build connections to the family, community, and culture
- Building up a sense of dignity and strength
- Tapping into spiritual beliefs
- Using intergenerational approaches
- Preparing children to live in two cultures and cope with racism
- Incorporating values from traditional teaching, such as 24-hour staff availability
- Recognizing and treating personal and cultural trauma
- Strengthening the community
- Using the native language
- Treating substance abuse and forbidding alcohol and drugs at events
- Respecting diversity within the tribe
- Using conventional services, such as counseling and health care services.



During the boy's month-long hospitalization, Ms. Smith explored the possibility of enrolling him in Sacred Child's program. She also spent a lot of time simply talking with the staff. Those conversations, which helped the staff gain Ms. Smith's trust, illustrate another key difference between American Indian and mainstream approaches. While conventional mental health professionals strive to maintain boundaries, Sacred Child's staff recognizes that American Indians typically consider that approach antisocial or even frightening.

When Ms. Smith's son emerged from the hospital, Sacred Child had a place waiting for him. He has been enrolled in the program for the last 2 years and has changed dramatically. Once withdrawn, this young man is now a confident teenager. He attends school regularly. And he's able to set goals and see them through to completion.

For Ms. Smith, it was the program's system-of-care approach that made her son's transformation possible. "Someone from Sacred Child was always there to listen to me and to encourage me," said Ms. Smith. "No one ever told me what I should do or told me that what I was doing was wrong. We were able to figure out for ourselves as a family what we needed to do. And the support team was always right there to help follow up."

But her son is not the only one who has changed. At first, Ms. Smith blamed herself for her son's troubles. As someone who had suffered through boarding schools, foster homes, alcoholism, and domestic violence, she feared she might have taught her children self-destructive behavior patterns. Working with Sacred Child turned her around.

Today Ms. Smith is herself a care coordinator at Sacred Child. She's a college student. And she's sober. "Now I have a positive attitude, and I've learned how to communicate openly and honestly with my kids and others," she said. "I would never have learned any of these skills if it hadn't been for Sacred Child."

For a copy of *Cultural Strengths and Challenges in Implementing a System of Care Model in American Indian Communities*, contact Hardy Stone, Director of Communications, CMHS Child, Adolescent, and Family Branch, Room 11C-16, 5600 Fishers Lane, Rockville, MD 20857. E-mail: **hstone@samhsa.gov.** Telephone: (301) 443-1333.

* A pseudonym

SAMHSA Reauthorization Brings New Flexibility, Accountability

The Children's Health Act of 2000 reauthorizing SAMHSA programs included the Agency's two major objectives—consolidating discretionary grant authorities and moving the Agency's Block Grant programs to "performance partnership" programs. The Act seeks to ensure flexibility in responding to substance abuse prevention and treatment and mental health needs of regional and national significance. The intention also is to give states more flexibility in their use of funds but more accountability for outcomes based on performance measures.

The Act also includes several new discretionary grant programs, language allowing religious-based organizations that receive Federal funds for substance abuse services to maintain their religious character and to hire persons of the same faith, and new Federal standards for the use of seclusion and restraint. In addition, the legislation contains language waiving certain requirements for qualified physicians who prescribe or dispense Federally approved narcotic drugs for the treatment of heroin abuse.

Performance Partnership Grants

Some flexibility is given to the states in the Community Mental Health Services Performance Partnership Grants by reducing the number of elements—from 12 to 5—that states must include in their plans for use of the funds. The bill also gives responsibility to the already existing State Planning Councils to review and comment on state reports.

Flexibility in spending is enhanced for states awarded funds through the Substance Abuse Prevention Performance Partnership Block Grants by the creation of a general waiver authority for seven requirements. The Act also provides a new emphasis on data collection and outcome analysis. States that receive certain designated funds are required to provide a core set of data to SAMHSA.

The intention is to give states more flexibility in use of funds but more accountability for outcomes. . . .

As part of the movement to performance-based systems, the Health and Human Services (HHS) Secretary is required to submit to Congress within 2 years a plan for what these performance-based programs would look like and how they would operate. This plan would include how the states are to receive greater flexibility, what performance measures are to be used in holding states accountable, definitions for the data elements that are to be collected, the funds needed for this system to function and a source of those funds, and necessary legislative changes.

Seclusion and Restraints

The legislation requires that hospitals, intermediate care nursing facilities, and other health care facilities receiving appropriated funds from any Federal agency protect and promote the rights of each resident of the facility. These protections include the right to be free from physical or mental abuse, corporal punishment, and from any restraints or involuntary seclusion imposed for purposes of discipline or convenience.

The legislation also sets standards for situations in which use of restraints or seclusion is allowed. Further, the Act requires each facility that provides mental health services to notify the appropriate state licensing or regulatory agency of any deaths that may occur while patients are in seclusion or restraints. Notification is also required for a death that occurs within 24 hours after a patient has been released from seclusion or restraints, or in any case where it is reasonable to assume that a patient's death is the result of seclusion or restraints.

The Act imposes similar requirements on nonmedical facilities for children and adolescents supported in whole or in part with funds appropriated under the Public Health Service Act. To protect and promote the rights (including those described above) of each resident of the facility is mandatory.

Co-Occurring Disorders

The legislation clarifies that money from both the substance abuse and mental health block grants may be used to provide services for people with co-occurring mental and addictive disorders. However, substance abuse funds may be used only for the substance abuse part of the treatment and mental health funds may be used only for mental health care.

The Act authorizes $50 million for a new grant to develop and expand programs to provide integrated treatment for individuals with both a serious mental and addictive illness. Further, it requires the HHS Secretary to report on how services are provided to people with co-occurring

disorders and to recommend treatment practices within 2 years after enactment of the legislation.

Waiver Authority for Physicians

A waiver in the legislation from the requirements of the Narcotic Addict Treatment Act would permit qualified physicians to prescribe and dispense Schedule III, IV, or V narcotic drugs for the treatment of heroin addiction. This enables qualified physicians to provide treatment with the approved drug in their offices for up to 30 patients. This would also permit qualified physicians to use buprenorphine to treat heroin addicts in their offices once the Food and Drug Administration approves the drug for use beyond clinical trials.

In addition, the HHS Secretary is required to issue regulations on criteria and practice guidelines for dispensing such medication.

Safeguards for Religious Providers

This portion of the Act permits religious organizations that provide substance abuse treatment services to receive Federal funding while maintaining their religious character and their ability to hire individuals of the same faith. However, Federal funds may not be used for sectarian worship, instruction, or proselytizing. Such programs may not discriminate against anyone interested in treatment at the facility—including persons with a different religion.

Discretionary Grants

Services for children and adolescents are enhanced through authorization of $100 million for grants developing ways to assist them in dealing with violence. This will continue the activities launched in 1999 by SAMHSA's Center for Mental Health Services (CMHS), the Safe Schools/Healthy Students program. In addition, $50 million is authorized to develop knowledge about practices for treating emotional disorders among children resulting from witnessing or experiencing domestic, school, and community violence and terrorism.

Grants are also authorized to train teachers and other relevant school personnel as well as emergency personnel to recognize symptoms of childhood and adolescent mental illness and to make referrals for treatment.

The Act includes a provision authorizing $75 million to establish suicide prevention programs for children and adolescents.

The High Risk Youth program, developed and directed by SAMHSA's Center for Substance Abuse Prevention (CSAP), is reauthorized to continue programs for the prevention of drug abuse among high-risk youth. Other substance abuse treatment funding authorized for children and adolescents includes $40 million to enable organizations to provide substance abuse treatment services for this age group as well as $20 million for the purpose of providing early intervention substance abuse services for children and adolescents.

A total of $40 million is authorized to help state and local juvenile justice agencies provide aftercare services for youth offenders who have or are at risk for serious emotional disturbances and have been discharged from juvenile justice facilities. A total of $4 million is authorized to establish centers to provide technical assistance to states and local jurisdictions to offer appropriate care for adolescents with severe emotional disturbance involved with the juvenile justice system.

The Act includes a provision authorizing $75 million to establish suicide prevention programs for children and adolescents.

The legislation also transfers a program providing services for children of substance abusers from the Health Resources and Services Administration to SAMHSA, and authorizes $50 million for the delivery of these services. A total of $20 million is authorized to integrate child welfare services and mental health services for children and adolescents.

The Act includes funding for programs pertaining to methamphetamine and inhalants as well as Ecstasy and other club drugs, underage drinking, and services for individuals with fetal alcohol syndrome.

The Act also authorizes $15 million for the HHS Secretary to make grants, contracts, or cooperative agreements with public and private nonprofit entities including American Indian tribes and tribal organizations and Native Alaskans for providing alcohol and drug use prevention or treatment services to these groups. Priority is given to those entities that will provide such services on reservations or tribal lands and employ culturally appropriate approaches, and that have provided prevention or treatment services for at least 1 year prior to applying for a grant. The HHS Secretary is required to submit a report to Congress after 3 years and annually thereafter describing the services provided under this program.

Other mental-health-related provisions of the Act include funding of programs for homeless individuals, emergency mental health centers, and jail diversion of persons with mental illness.

SAMHSA Appropriation Increases

Federal funding for Fiscal Year 2001 for SAMHSA's programs increased by 11.6 percent over last year's appropriation for a total of $2.9 billion. This level of funding acknowledges the importance of the Agency's mission and the valuable work of stakeholders in the prevention and treatment fields.

The Mental Health Block Grant was funded for a total $420 million, which represents an 18-percent increase over last year's appropriation. The Substance Abuse Block Grant also increased by 4.1 percent to a total of $1.7 billion.

The appropriation includes $635 million—a 27.6-percent increase over last year—for substance abuse and mental health Programs of Regional and National Significance, a category comprised of SAMHSA's Knowledge Development & Application (KDA) program and the Targeted Capacity Expansion (TCE) program. The KDA program focuses on improving treatment and prevention services by developing new information and ensuring that this information is put into clinical practice. The TCE program supports local and regional efforts to respond rapidly and strategically to emerging substance abuse treatment needs. The appropriation for mental health-related Programs of Regional and National Significance, in particular, increased by 49 percent.

In addition, three formula grant programs administered by SAMHSA's Center for Mental Health Services were funded as follows: Children's Mental Health Services received $91.8 million; the Protection & Advocacy Program, $30 million; and the PATH formula grant, which addresses homelessness, received $36.9 million.

SAMHSA's National Household Survey on Drug Abuse, which provides annual estimates of the prevalence of illicit drug, alcohol, and tobacco use in the United States and monitors trends in use over time, received $12 million. This funding will allow the survey to expand and improve its findings.

Dr. Sanchez-Way Named Prevention Director

Ruth Sanchez-Way, Ph.D., has been appointed Director of SAMHSA's Center for Substance Abuse Prevention (CSAP). As CSAP Director, Dr. Sanchez-Way develops Federal policy, advises the SAMHSA Administrator and other senior officials on policy and program matters, and provides leadership on a number of important CSAP initiatives and activities, including SAMHSA's Substance Abuse Prevention and Treatment Block Grant program to the states.

Ruth Sanchez-Way, Ph.D.

Dr. Sanchez-Way most recently served as Director of the CSAP Division of State and Community Systems Development. This Division assists states and communities with developing their preventive systems and with developing and applying science-based prevention methodology and technology. Dr. Sanchez-Way has served as both the Acting CSAP Director and the Acting CSAP Deputy Director. As SAMHSA's former Associate Administrator for Minority Health Concerns, she was responsible for monitoring and coordinating SAMHSA-wide prevention and treatment activities, and programs that address the changing needs and concerns of racial/ethnic minority populations.

Dr. Sanchez-Way currently serves as a national operational volunteer for Girl Scouts of the U.S.A. She has served as an officer and member on several national boards, including the National Health Council; the National Organization on Adolescent Pregnancy, Parenting, and Prevention; and the National Council on Alcoholism and Drug Dependency. She is also co-founder of the National Organization of Latino Social Workers.

Dr. Sanchez-Way received a Ph.D. in Public Administration from New York University, an M.S.W. from Fordham University, and a B.S. degree in Science from St. John's University, New York.

— By Brian Campbell

Dr. Chavez Departs; Dr. Autry Is SAMHSA Acting Administrator

After more than 6 years as SAMHSA Administrator, Nelba Chavez, Ph.D., submitted her resignation effective December 9.

Nelba Chavez, Ph.D.

As SAMHSA's first appointed Administrator, Dr. Chavez guided the Agency during a time of numerous transitions including reorganization, downsizing, and the restructuring of SAMHSA's discretionary grant programs.

During her tenure, SAMHSA made significant contributions in reducing teen drug use. After increases in the early 1990s, drug use rates among youth leveled off and are now declining. SAMHSA's National Household Survey on Drug Abuse documented this and other trends.

SAMHSA, working in partnership with its constituency groups, saw its budget appropriation rise from $2,150,178 when Dr. Chavez arrived in 1994 to $2,958,001 in 2001—an increase of 37.5 percent.

In 1997, as part of the Health and Human Services Secretary's Initiative on Youth Substance Abuse Prevention, SAMHSA launched the State Incentive Grant Program for Community-based Action, and over the years, expanded the National Household Survey on Drug Abuse to provide governors, state authorities, and program administrators with additional information for planning efforts to combat drug use.

Also in 1997, SAMHSA launched the Starting Early Starting Smart Initiative, a unique collaboration with the Casey Family Program to identify and intervene in circumstances that could contribute to mental and addictive problems in young children whose family or community environments put them at risk.

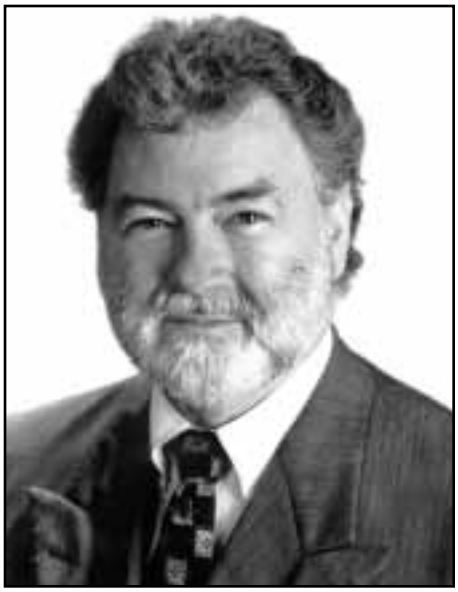
Last year, SAMHSA partnered with the Departments of Education and Justice to launch the Safe Schools/Healthy Students Initiative to develop school-based programs that promote mental health, healthy childhood development, and resilience to avoid violent behavior, drugs, and alcohol.

Also last year, the Agency helped to convene the historic White House Conference on Mental Health and released the first-ever Surgeon General's Report on Mental Health.

Most recently, SAMHSA achieved its first reauthorization in the form of legislation by Congress that significantly added to the Agency's responsibilities.

Prior to serving as SAMHSA's Administrator, Dr. Chavez was Director of Juvenile Probation Services for the city and county of San Francisco, and served from 1978 to 1989 as Executive Director and chief executive officer of La Frontera Center, a comprehensive community mental health center based in Tucson, AZ.

SAMHSA Deputy Administrator Joseph Autry III, M.D., is serving as SAMHSA Acting Administrator. Prior to his role as Deputy Administrator, Dr. Autry was Acting Deputy Director of SAMHSA's Center for Substance Abuse Prevention (CSAP) in 1997 and 1998 during a period of transition in leadership. He also served as Director of CSAP's Division of Workplace Programs. Prior to his work at SAMHSA, Dr. Autry held a number of leadership positions at the National Institute for Mental Health and the National Institute on Drug Abuse. He received his medical degree from the University of Tennessee Medical School.



Joseph Autry III, M.D.

Upon leaving, Dr. Chavez said, "I will continue to work on behalf of the Nation's children and advocate for the needs and concerns of consumers of substance abuse and mental health services, their families, and their communities. There is still so much to do and, for too many people, there is still too little time."

Girl Power! Celebrates 4th Anniversary

The Department of Health and Human Services (HHS) commemorated the fourth anniversary of G*irl Power!* in November by unveiling an assignment book and two new areas of the *Girl Power!* Web site.

Launched in 1996 by HHS with leadership from the Office of the Secretary, the Office on Women's Health, and SAMHSA's Center for Substance Abuse Prevention, *Girl Power!* is a national public education campaign to help encourage and motivate 9- to 14-year-old girls. The *Girl Power!* Web site has received more than 45 million hits since its launch and received an average of 1.9 million hits per month in the year 2000.

Girl Power! celebrated its fourth anniversary in conjunction with Outward Bound's "Girls on the Move" daylong festival in New York City's Central Park. This festival culminated a 10-week, cross-country bicycle ride to celebrate women and to raise awareness about critical issues surrounding young women.

The assignment book provides a place for girls to keep track of homework and other school-related activities and has suggested homework tips. The book also provides "tips for success" told firsthand by successful women, including sports figures, journalists, heads of large organizations, and other women of influence. The book celebrates cultural diversity, highlights significant health-related observances, and provides health facts and resources. The book is intended to help girls build discipline and good habits by giving them a special place to plan and organize school-related deadlines and homework assignments.

The *Girl Power!* fourth anniversary also marks the introduction of two new areas of the *Girl Power!* Web site: Science and Technology, and Chronic Illnesses and Disabilities. The focus of the Science and Technology area is to show girls how this exciting and emerging field relates to them and to their future career choices. The area provides links for homework help, job information, and featured guests. The Chronic Illnesses and Disabilities area provides constructive information to girls in this age group about taking charge of their bodies and their health.

The *Girl Power!* campaign provides accurate health information and positive messages to girls and their caregivers. The campaign raises public awareness about substance abuse and risky behaviors, helps girls develop the skills they need to make positive choices and resist unhealthy influences, and supports girls and the adults who care about them.

The campaign also challenges caring adults to reach out to young girls at this transitional age when they are forming their values and attitudes, and to help them pursue opportunities to build skills and self-esteem through sports, academics, the arts, and other endeavors. Studies show that girls tend to lose self-confidence during this pivotal age, become less physically active, perform less effectively in school, and neglect their own interests and aspirations. It is during these years that girls become more vulnerable to negative outside influences and to mixed messages about risky behaviors.

To date, *Girl Power!* has teamed with nearly 5,000 community-based programs and organizations, more than 400 local endorsers and more than 65 national endorsers including the American Association of University Women, the American Medical Association, and the Girls Scouts of the U.S.A., to promote the *Girl Power!* message nationwide.

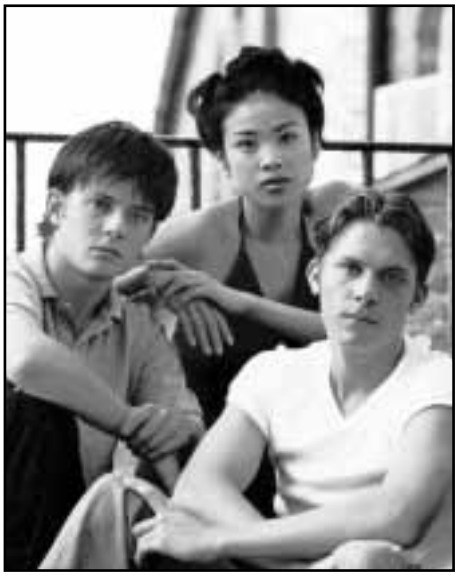
To receive the *Girl Power!* assignment book, contact SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) at P.O. Box 2345, Rockville, MD 20847-2345. Telephone: 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD). Web access: Type **www.samhsa.gov,** click on SAMHSA's Clearinghouses, click on PREVLINE, and click on *Girl Power!* Assignment Book, or go directly to the Web site at **www.health.org/gpower**.

Youth Call For Improvements in Treatment

Young people with co-occurring mental health and substance abuse problems and their family members called for improved mental health and substance abuse services in a report this fall funded by SAMHSA's Center for Mental Health Services (CMHS). Titled *Blamed and Ashamed*, the report is based on a study conducted by two organizations—the Federation of Families for Children's Mental Health, in Alexandria, VA, and Keys for Networking, Inc., in Topeka, KS.

The report presents the findings of a 2-year project intended to document and summarize the experiences of youth with co-occurring mental health and substance abuse problems and their families. The purpose of this study was to formulate recommendations so that a national audience might learn from their experiences and improve services.

"*Blamed and Ashamed* gives us the real-life picture of what children and families are experiencing," said CMHS Director Bernard S. Arons, M.D. "The



knowledge that consumers and family members bring is invaluable in solving the crisis in children's mental health and substance abuse service systems."

A unique and key feature of the study is that it was conducted by young people. The report was developed from interviews and focus groups conducted from 1997 to 1999 with over 150 individuals from California, Georgia, Illinois, Kansas, Maine, New Mexico, Virginia, West Virginia, and Washington, DC. A team of youth trained as researchers designed the questions. They carried out the focus groups and interviews, and they analyzed the data.

The findings identify the need for individualized services and for youth and family education, as well as the need to develop public awareness of mental health issues and to promote collaboration between substance abuse and mental health systems, agencies, and providers.

The report's recommendations—directed at providers, family members, youth, and SAMHSA—call for increased peer support for youth and families, expanded access to accurate and useful information, and combined services.

For a copy of the report, contact the Federation of Families for Children's Mental Health at 1101 King Street, Suite 420, Alexandria, VA 22314. Telephone: (703) 684-7710. Or contact Keys for Networking at 117 Southwest 6th Avenue, Topeka, KS 66603. Telephone: (785) 233-8732.

Make Time To Listen . . . Take Time To Talk

Make Time to Listen . . . Take Time to Talk . . . 15+ Communications Campaign for Parents/Caregivers, a campaign designed to foster improved communications between parents and their children, was launched this fall by SAMHSA's Center for Mental Health Services (CMHS) in partnership with WJLA-TV Channel 7 in Washington, DC. The campaign, part of the CMHS School Violence Prevention Initiative, contains key messages to parents and caregivers on ways to communicate with their children.

"The focus of this Federal/media partnership is to show that when parents and caregivers spend 15 minutes *(plus)* of undivided time every day listening and talking with each of their children, remarkable changes are possible," said CMHS Director Bernard S. Arons, M.D.

CMHS and WJLA-TV Channel 7 developed four 30-second public service announcements (PSAs) and one 10-second PSA. Each PSA targets a different audience. The PSAs, which aim at reaching parents and caregivers in the Washington, DC, metropolitan area, will be aired during the 2000–2001 school year.

Other components of the campaign include:

- *Make Time To Listen . . . Take Time To Talk . . . 15+.* A brochure that discusses ways parents and caregivers can be role models for their children to help keep them violence free.
- *Conversation Starter Interactive Card Game.* This interactive question-and-answer card game provides a comfortable and fun way for both the parent or caregiver and the child to begin to talk and to listen to each other. The basis of the game is to get to know more about your family, friends, and caregivers by answering the questions on each card honestly and listening to replies carefully.
- *Prevention Works—Substance Abuse Resource Guide "Violence in Schools"—* The recent incidences of school violence across the country are a wakeup call. Resources listed in this guide are designed to help answer that call and ensure a safe learning environment in schools.
- *Bright Futures for Families—What You Can Do To Prevent Violence.* This brochure offers a variety of materials on health and childhood development to help families raise healthy children. For use with children of all ages, the brochure shows how to prevent violence in the home and the community.
- *Keeping Youth Drug Free.* This brochure provides parents and caregivers with guidelines to help them make the most of the influence they have on their children, despite worries about the negative effects of peer pressure and pop culture. It is targeted to parents and caregivers of 7- to 13-year-olds, but the materials and exercises can also work for other age groups. The key is to talk to your children—often and early. Send clear and consistent messages that you don't want them using alcohol, tobacco, or drugs.

For copies of these materials, contact SAMHSA's National Mental Health Services Knowledge Exchange Network (KEN) at P.O. Box 42490, Washington, DC 20015. Telephone: 1 (800) 789-CMHS (2647) or (301) 443-9006 (TTY). Web access: Type **www.samhsa.gov,** click on SAMHSA's Clearinghouses, and then click on KEN.

Teens Buying Cigarettes? It's Harder Than Ever

Before 1996, young people could walk into most retail outlets in the United States and purchase tobacco products. Although no nationwide data were collected, community-based studies indicated that as many as 60 to 90 percent of sales outlets sold tobacco to minors (youth under age 18).

The Synar Amendment, part of the U.S. Department of Health and Human Services (HHS) comprehensive strategy to protect children from tobacco, was passed in 1992 to reduce access by minors to tobacco products. The goal of the Synar Amendment—named for its sponsor, the late Congressman Mike Synar of Oklahoma—is to reduce access to cigarettes by youth under age 18. The procedures developed by the regulatory process set the measurable target to reduce the violation rates (successful attempts by minors to purchase tobacco products) to no more than 20 percent in all states and U.S. jurisdictions by 2003.

In Fiscal Year 1997, the first year national statistics were compiled, the violation rate was approximately 40 percent. Progress toward reaching the 20 percent target has been steady. In 1997, only four states reached the 20-percent goal; in 2000, 24 states reached that target. Most other states and jurisdictions, even if they have not yet reduced their violation rate to 20 percent, are meeting their annual targets and moving toward 20 percent by 2003. In fact, in 2000, only four states and two U.S. jurisdictions did not meet their annual targets. Moreover, many States—including California, Florida, Louisiana, Massachusetts, and Washington—are well below the 20-percent violation rate.

Figures released in November 2000 for FY 2000 show that the violation rate, as a weighted national average, did decrease to 20 percent. What this means is that even though every state has not attained the 20-percent goal, the average violation rate, when looked at nationwide, has been reduced to 20 percent. This 20-percent rate meets one of the objectives of Healthy People 2000, the prevention agenda issued in 1990 by HHS. Healthy People 2000 presents more than 300 objectives that aim to increase years of healthy life, reduce health disparities among different population groups, and achieve access to preventive health services.

SAMHSA was charged with developing the regulation to carry out and accomplish the goals of the Synar Amendment. The Synar Regulation, issued in 1996, requires states and jurisdictions to do the following:

1. Enact laws prohibiting any manufacturer, retailer, or distributor from selling or distributing tobacco products to youth under age 18.
2. Enforce the laws in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to people under age 18.
3. Conduct annual random, unannounced inspections to ensure compliance.
4. Develop a strategy and timeframe for achieving an inspection failure rate of less than 20 percent of outlets accessible to minors.
5. Submit an annual report describing activities to enforce the law.

The amendment penalizes noncomplying states through a 40-percent decrease in their Substance Abuse Prevention and Treatment Block Grants. Because this penalty could represent a loss of millions of dollars, depending on the

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state, Congress and HHS worked on ways to reduce youth access while providing some flexibility in the penalty, especially for states that are very close to the 20-percent goal. For the past 2 years, noncomplying states avoided the penalty by committing some of their own money (the exact amount is based on a specific formula) toward stepped-up tobacco control and enforcement.

No studies have proved that restricted access leads to a decline in youth smoking rates, but initial indications are that rates are flattening or declining in states with the most restricted access. However, these states also tend to have the most comprehensive anti-tobacco programs, so it is difficult to separate restricted access from other interventions.

To help local enforcement efforts, SAMHSA's Center for Substance Abuse Prevention (CSAP) has produced a video and a manual to train teenage inspectors who participate in random checks of retail outlets, guidance documents to help states carry out scientifically credible and reliable random checks, a publication on barriers to enforcement and strategies to overcome them, and other resources.

For more information, contact SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) at P.O. Box 2345, Rockville, MD 20847-2345. Telephone: 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD). For Web access: Type **www.samhsa.gov/csap/synar/sydex.htm.**

Elements of Success

How have some states made significant progress in reducing youth access to tobacco products? In reviewing many programs across the country, CSAP noted these common threads:

1. Effective laws. At this point, all states and jurisdictions have laws that make the sale of tobacco products to minors illegal. The most effective of these laws carry appropriate penalties. For example, a fine will escalate depending on how many times a retail outlet is in violation. These laws also clearly identify the entity responsible for enforcement.

2. Comprehensive enforcement. States with the lowest violation rates are enforcing their laws thoroughly, not just the minimum amount required to comply with the Synar regulation.

3. Consistency of mission. In the most successful states, the agency empowered to carry out the law has the resources to do the job well and coordinates its efforts with others. For example, if the agency needs a list of retail outlets, it can easily get one from the state's department of taxation.

Initiative Teaches Health Professions About Substance Abuse

In an effort to educate those who teach future physicians, nurses, pharmacists and other medical personnel about substance abuse and how to recognize the symptoms, SAMHSA's Center for Substance Abuse Treatment (CSAT) is supporting development of a training program to teach faculty members in health professions about screening and referral of patients who exhibit signs of alcohol or drug addiction.

The Interdisciplinary Faculty Development Program To Improve Substance Abuse Education will provide educators working in interdisciplinary teams with the background and resources to teach students how to recognize substance abuse, how to talk to their patients about alcohol and drug abuse, and when to refer patients to treatment professionals. The effort will involve educators in 15 health professions. Currently, schools for health professionals lack faculty who can teach their students basic competencies on substance abuse.

"Today, a patient who falls off his porch is treated for his bumps and bruises, maybe sent to a specialist if there is a broken bone," said CSAT Director H. Westley Clark, M.D., J.D., M.P.H. "Our goal is to equip primary care providers with the ability to determine if this occurrence is due to an accident or caused by underlying alcohol or drug abuse. Our system of health care is constantly treating the symptoms, but not recognizing the root cause in order to recommend specialized addiction treatment. We want this training to address these deficiencies," Dr. Clark said.

The $1 million program is offered in partnership with the Health Resources and Services Administration's Bureau of Health Professionals and will be conducted by the Association for Medical Education and Research in Substance Abuse. For additional information on the training program, visit **www.amersa.org.**

We Would Like To Hear From You!

SAMHSA News strives to keep you informed about the latest advances in treatment and prevention practices, the most recent national statistics on mental health and addictive disorders, relevant Federal policies, and available resources.

Are we succeeding? We'd like to know what you think.

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Editor
SAMHSA News

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